	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
***					С
		IL6013312	B. WING		09/15/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, RTH STATE :	STATE, ZIP CODE	
JERSEY	VILLE MANOR		ILLE, IL 62		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETE
S9999	Final Observations		S9999		
270	Statement of Licens	sure Violations			
			no constituente de la constituen		
	300.610a) 300.1210b) 300.1210b)4) 300.1210c) 300.1220b)3) 300.3240a)				
	procedures governir facility. The written per formulated by a Formulated by a Formulated consisting administrator, the acmedical advisory coron formulated and other policies shall comply. The written policies the facility and shall	nave written policies and all services provided by the policies and procedures shall Resident Care Policy ag of at least the dvisory physician or the mmittee, and representatives a services in the facility. The with the Act and this Part. Shall be followed in operating be reviewed at least annually ocumented by written, signed			
	Nursing and Persona b) The facility shall p and services to attain practicable physical, well-being of the resi each resident's comp plan. Adequate and p care and personal ca	eneral Requirements for al Care rovide the necessary care or maintain the highest mental, and psychological ident, in accordance with prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal		Attachment A Statement of Licensure Vio	lations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 10/05/15

PRINTED: 11/04/2015 FORM APPROVED

Illinois Department of Public Health

1	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	:	İ		
		IL6013312	B. WING		1	C 15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
JERSEY	VILLE MANOR		RTH STATE : 'ILLE, IL 62				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	care needs of the reaction activities of daily circumstances of the demonstrate that didenonstrate that dide	esident. nnel shall assist and so that a resident's abilities living do not diminish unless e individual's clinical condition minution was unavoidable. sident's abilities to bathe, ransfer and ambulate; toilet; n, language, or other cation systems. A resident rry out activities of daily living rvices necessary to maintain ming, and personal hygiene. giving staff shall review and about his or her residents' care plan. upervision of Nursing upervise and oversee the the facility, including: to-date resident care plan for an on the resident's essment, individual needs omplished, physician's orders, and nursing needs. Personnel, ervices such as nursing, and such other modalities as shysician, shall be involved in e resident care plan. The ang and shall be reviewed and with the care needed as dent's condition. The plan least every three months.	S9999				
;	agent of a facility sha	all not abuse or neglect a					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		E SURVEY PLETED
ANDFLAN	OF COMEONON	IDENTIFICATION NOWBER.	A. BUILDING	3;	COIVII	PEELED
			D WING			С
		IL6013312	B. WING		09/	15/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JERSEY	VILLE MANOR		TH STATE			
	CLUMANOVOTA		ILLE, IL 62			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
S99 9 9	Continued From pa	ge 2	S9999			
	resident. (Section 2	-107 of the Act)				
	These requirements	s are not met evidenced by:				
	review, the facility farmonitor for weight lo implement intervent meals and decrease maintain residents (R3, R7 at loss in a sample of 8	s, observations and record ailed to identify, assess and oss, and failed to develop and ions to address refusals of ed food consumption to nutritional status for 3 of 4 and R8) reviewed for weight B. This resulted in R3 having loss, 8.4 % in one month,				
	Findings include:					
		2015 Physician's Order Sheet 3 is to receive a puree diet.				
	documents R3 as ha	Set (MDS), dated 6/16/2015, aving cognitive deficit and istance of one staff for eating.				
	problem as having a leaves more than 25 8.4% weight loss (ac one month. R3's Cal present diet without stabilize during this ridentify her at an ele Interventions include weight and record with monitor labs, staff to medication review. Intervention was revintakes per Registere	ed 3/31/15, documents R3's Diagnosis of Dysphagia, 6% or more uneaten and an dided in August 2015) noted in re Plan Goal is to tolerate complications, and weight will review period but does not vated risk of weight loss. It diet as ordered, monitor eekly and as needed (PRN), assist as necessary and On 6/25/2015, the Care Plan ised to monitor and record and Dietician (RD) request.				
		but 16 pounds weight loss in				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		SURVEY PLETED
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		IL6013312	B. WING		1	C 15/2015
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
JERSEY	VILLE MANOR		ORTH STATE S			
			YVILLE, IL 620			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
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	delivered. She ate less than 25% of he 50% of her vegetab carton of Impact. Sor HCHP. Intake re 26-50% of her even There is no docume Care regarding R3's needed to eat from	entation or revision of Plan of s increase in assistance the MDS, dated 6/16/15, tified as needing only				
	noon meal on 9/9/1: only 62 of 83 meals food intake totals, 1 intake at all and 29 as only eating 1-259 was documented tw for 1-25%. For the 6 R3's daughter was p her supper meal, sta On 9/15/15 at 3:15 F Nurse (LPN), stated R3 until 8/13/15 who opened even though loss in February 201 On 9/15/15 at 3:03 F provide the Impact of what percentage is of could work out that F mealtime if it's given	PM, E11 stated nurses cartons, but do not record consumed. E11 stated it R3 gets the Impact at AM and PM.	al :			
1	Protein supplement	ver Pudding, High Cal/High along with her full meals t nothing in between				

Illinois Department of Public Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G:	COMPL	_ETED	
					c		
		IL6013312	B. WING		09/1	5/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
JERSEY	VILLE MANOR		TH STATE				
			ILLE, IL 62				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 4	S9999				
	and choking, or who	en her intake is consistently					
		9/2015, documents R3 should 5 milligrams (mls) every					
	supplement) was no	der for Impact (nutritional ot received until 9/8/15, weeks after the RD made the					
	she has the feeling her mother to eat as she was eating in the she had previously dining room. Z1 states on the eve of 9/4/15 ate 100% of her methe lack of assistant moved back to the 2 past several days. 9/4/15, R3 still ate in she noted staff not p	M, Z1, R3's daughter, stated that staff really didn't assist a much as they could when he Main Dining room and that been eating in the 200 hall ted she went into the facility and fed R3 supper which she hal. Z1 stated she discussed be with the facility and R3 was 200 hall dining room in the Z1 stated on the eve of the main dining room and providing consistent help in dents in that dining room.					
THE TAX IS THE COMMENTAL PROPERTY OF THE COMMENTAL PROPERTY OF THE COMMENTS OF	the 200 hall dining rassistance from E6, when her plate was participate in feeding her eyes, refused to her head. R3 requir cues/encouragemer 25%. R3 did not ear consumed less than supplement.	nt to eat and ate less than t her power pudding and 50% of her HCHP					
9	On 9/12/15 at the su	pper meal, R3 was again			1		

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		SURVEY
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMF	PLETED
Anna Anna Anna Anna Anna Anna Anna Anna		IL6013312	B. WING			C 15/2015
NAME OF	PROVIDER OR SUPPLIER	STDEET AD	DDESS CITY S	STATE, ZIP CODE		. 071010
T-S-S-S-S-S-S-S-S-S-S-S-S-S-S-S-S-S-S-S			RTH STATE S			
JERSEY	VILLE MANOR		ILLE, IL 620			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(25)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	Continued From pa	ge 3	S9999			
	past year with her was pounds. R3's RD not documented R3's was mechanical soft diet requires assistance documents R3 holds cheeks, coughing/cheeks, coughing/ch	reight recorded as 143 ote, dated 6/15/15, eight as 133 pounds, on a t, eats 25-50% of meals, and in eating. The note also is food in her mouth and noking during meals, and has der (PO), dated 6/25/2015, receive a High calorie/High				
	documents her as her of 8.4% in one month in 6 months. The Evocurrent weight as 12 weight loss in one m documents R3 has a refuses meals, diet r liquid puree per SLP recommendation for protein) supplements recommended "Impa BID (twice daily), mastimulant." On 8/17/15, the RD ress 120 pounds, down 22 pounds in 6 month documents, "Often resurred singular and singular	note documents R3's weight n 11 pounds in one month, ns. The RD note also sfusing meals, diet downed				
t	wice (BID) daily." R3 at this time to addres	ne suggested Impact 1 can 's Care Plan was not revised s R3's refusal of meals, outh and cheeks, coughing	THE PROPERTY OF THE PROPERTY O			the second secon

If continuation sheet 7 of 14

Illinois Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
,			A. BUILDING			0
		IL6013312	B. WING		1	15/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
JERSEY	VILLE MANOR		TH STATE S			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
S999 9	Continued From pa	ge 6	S9999			
	month of August sh centimeters) cc threwhen she consume documentation if R3 Pudding or of the Intwice daily. On 9/9/15 at 1:55 P stated R3 had a hot and although not dideep infarct" that waffected her oral phworsened in the pass	the HCHP supplement for the now she consumed 180 (cubic see times daily except 15 times and only 90 cc. There is no 3 consumed the Power impact which she receives of M, E7, Speech Therapist, spitalization in the summer agnosed, they think she had a was undetected that possibly hase of eating since it has set several months since that is not on a liquefied puree,				
	On 9/15/15 at 9:20 declining for a while there were days wh that the facility does between meals. E1: a snack between meals. E1: a snack between m that in an effort to ir staff may need an ir focus on when feed increase calories at does not typically w provide assistance. 2. The Admission F diagnosis include in Dysphagia. The MDS, dated 8/1 cognitive deficits an one staff to eat.	AM, E13 stated R3 has been e. E13 stated she didn't realize en R3 ate nothing, but added a pass snacks for everyone in 3 stated she didn't think to add eals, but that she could do no crease calories. E13 stated enservice in what foods to ling residents in a effort to mealtime. E13 stated she atch residents eat or staff				

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Illinois Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BOILDING	*	C
		IL6013312	B. WING		09/15/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
JERSEY	VILLE MANOR		TH STATE		
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECT	TION
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLETE
S9999	Continued From page	ge 7	S9999		
	nutritional supplement) 30 milliliter (ml) every day, Power pudding 3 times a day with meals x 2 days PRN and HCHP with meals.				
	problem as poor apploss and a diagnosis tolerate present diet next 90 days, but do weight loss. Interve record intakes per R record monthly weigh when available, offer dislikes, Remeron as as necessary all imploare Plan was revisintervention for HCH intervention was revisintervention was revisured diet. The Carevised on 8/17/2015 meal. A statement at (undated) document puree diet, 2 fortified fortified pudding at eand protein intake. R poor appetite." R7's RD note, dated weight as 165 pound Progress Notes, date E13, documented R7 a 9 pound weight los pounds down in last in 6 months. The no currently has a stage coccyx, outer heel and documented R7's Albert and the stage coccyx, outer heel and documented R7's Albert and the stage coccyx, outer heel and documented R7's Albert and the stage coccyx, outer heel and documented R7's Albert and the stage coccyx.	ised on 5/12/2015 for a are Plan intervention was for for fortified pudding at every the bottom of the Care Plan is "resident receives HCHP milks at every meal and 1 very meal to aide with calorie desident continues to have a 2/27/2015, documents R7's and his Albumin as 3.5. A and 8/17/15, written by the RD 7's weight is 154 pounds with s in the past month, 14 months, 21 pounds down the continues to document R7 all pressure ulcer on his			

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		IL6013312	B. WING		i .	C 15/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
JERSEY	VILLE MANOR		TH STATE			
			ILLE, IL 62	052		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 8	S9999			
	R7's weights show a from admission 5/4/pounds, to June 16/8/7/15 - 154 pounds 8/24/15 - 149 pounds on 8/31/15 to 154 pounds on 8/31/15 to 154 pounds on 9/10/15 at 11:15 wheelchair at the dir noon meal. R7 dost staff delivered a bowdrink at 12:04 PM. Adown briefly and gavapplesauce before gresidents meal trays when his plate was given a plate whised vegetables, pureed bread, a cup Styrofoam container bowl of power puddi milk. E15 fed R7 slofortified milk betwee stood up and remove consumed 100% of less than 25% of his R7 consumed 1 1/2 supplement but ate a pudding or peach co attempt to give him a and/or the ice cream from the table at 1:00 Meal intake records 9/14/15, of the 57 opmeal intake, recorde	a gradual weight loss monthly /15 when he weighed 168 5 pounds, July - 163 pounds, s, 8/17/15 - 152 pounds, ds, and an increase recorded ounds, then back down again /8/15. AM, R7 was sitting in his ning room table awaiting his ed off and then awoke when who f applesauce and a red At 12:05 PM, E14, CNA, sat we R7 a couple bites of getting up to deliver other s. R7 sat there until 12:21 PM delivered by E15, CNA. R7 hich had puree spaghetti, notatoes/gravy on it along with of peach cobbler, a of chocolate ice cream, a ng, and 2 glasses of fortified owly offering him sips of the n bites. At 12:45 PM, E15 ed R7's bib. He had his spaghetti and vegetables, potatoes and applesauce. glasses of the HCHP none of the ice cream, power obbler. E15 did not even any of the power pudding a before pushing him away 0 PM. document from 8/27/15 thru portunities to document R7's d only 40. Of those 40	S9999			
1	meal intake, recorde					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.			_
	IL6013312	B. WING		1	C 5/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JERSEYVILLE MANOR		TH STATE S ILLE, IL 620			
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
Nurse (LPN) stated to intake for any supple that R7's meal intake 8/27/15 even though was initiated 2/10/15 not been identified wo intakes weren't requive weight loss event for There is no documer a plan of care to additional less than 25% of intakes than 25% of intakes than 25% of intakes than 25% of intakes and a consistent admission. Again, Ethad no intake at all for she had not made an provide nutritional suphe got at meals. E13 "weight committee" the not attend herself. 3. The Admission Rediagnosis in part of All Phase dysphagia. The MDS, dated 6/16 extensive assist of or September 2015 POS receive a puree diet working of aspirations manufacturing supporting nutrition. encourage small bites	PM, E11 Licensed Practical the facility does not document ements but the HCHP and e was not recorded until the care plan documents it is. E11 stated since R7 had with significant weight loss, ired until they filled out a him. Intation the facility developed ress R7's refusal to eat or ake at meals. Interpolation weight loss since the gradual weight loss since that he gradual weight loss since that R7 for some meals and stated by recommendations to pplements other that what a last attended and the stated the facility has a that meets weekly, but does the staff for eating. The S documents R8 is to with HCHP 180cc/meal. In 19/24/15, documents the prescribed diet with no overt	S9999	DELI MENCI		

1111110101	oparamone or r abito	HOURT				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	PLETED
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		IL6013312	B. WING		1	5/2015
OF	PROVIDER OR SUPPLIER					
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JERSEY	VILLE MANOR		RTH STATE			
		JERSEYV	ILLE, IL 62	052		
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID.	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU		(X5)
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			Compose	DEFICIENCY)		
59999	Continued From pa	ge 10	S9999			
00000	•		00000			
		clear of food, monitor for				
		nose, coughing/choking and	Management of the contract of			
No.		ne sits up for 30 minutes after	alpa I handy			
The state of the s		goal documents to stabilize ut none identify R8's risk of	The state of the s			
		ntions include HCHP and				
		h therapy evaluation to follow.	CONTRACTOR			
	paroo alor, a opocor	in therapy evaluation to rollow.	And the little of the little o			4
	A Progress Note wri	itten by E13 RD, dated	depth of the second			
		R8's weight as 148 pounds,				
	12 pounds down in	one month. The note	entra de la companya			
		been spitting food out.	TO COMMANDE			
		include to change diet to	Consideration of the Constitution of the Const			
		ekly weights, and continue	The state of the s			
		e adds that R8's current Body	The state of the s			
		27.1, indicating overweight.	- m - m			
	2/27/15 170 pound	s are recorded as such: ls, 4/7/15 - 164 pounds,	A CONTRACTOR OF THE CONTRACTOR			
	5/4/15 - 163 pounds	s, 4/7/13 - 164 pounds, , 6/8/15 - 160 pounds, 7/6/15	Name of the state			
		5 - 148 pounds, 8/17/15 - 148				
		15 pounds, 8/31/15 - 150				
	pounds, and 9/8/15					
	,	, , , , , , , , , , , , , , , , , , , ,				
According to	On 9/10/15 at 11:15	AM, R8 was sitting at the				
		om awaiting her noon meal.		TO OPPOSE ALL AND		7
		A delivered a bowl of		TO THE PROPERTY OF THE PROPERT		
		ed drink to R8. R8 picked up				
		nt hand and attempted to eat				
		ny intervention from staff. E6				
		ter after giving a table mate a		THE STATE OF THE S		
		oplesauce. At 12:24 PM, delivered to her in separate				
		owl of spaghetti with white				4
		f bread, vegetables, peach				
(dessert, potatoes an	d a Styrofoam container of		- Landau de la casa de		
		. E15 CNA was sitting at		***************************************		
	R8's right side feedin					- Andrews
		need help?" as R8 took an				:
		od but did not cue and/or				
		food or to use the proper				

111111010	roparation of a abito	1 (Gara)				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION		SURVEY
ANDICAN	OF CONNECTION	BERTH IOATION NOMBER	A. BUILDING			
		11 6042242	B. WING	9	1) IE/ODAE
Annual Control of the		IL6013312	1		1 09/1	5/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JERSEY	VILLE MANOR		RTH STATE S VILLE, IL 620			
(1.1.1) 1995	CHAMADVCTA	TEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	ON	(345)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 11	S9999			
	utensil. At one point, R8 was attempting to eat her ice cream with her right hand only due to		entra standarda e e e e e e e e e e e e e e e e e e e			- Children on the Children
	being unable to use	to her left due to paralysis. m container about the table in	Market et de la company de la			
	an effort to load her	spoon until she finally				
	managed to push it against another dish and take a bite. This continued with no assistance. R8 ate none of her spaghetti, vegetable, or bread and only 50% of the peach dessert and 100% of her potatoes. She drank none of the fortified milk and 100% of her red drink. Meal intake records document she ate 26-50% of her lunch meal		TOTAL COMMON TOTAL			
1			And the state of t			
			The state of the s			
and the state of t			Transmitted (polygogogogogogogogogogogogogogogogogogog			
	which is inaccurate.					
		upper meal, R8 was sitting at I. She did not receive any	The state of the s			
	salad as others in th	ne dining room did but sat at				
		s of water and lemonade in PM, E16 delivered R8's meal				
TO THE MICHIGAN PROPERTY.		ad puree bread, green beans, und meat, power pudding, ice				
	creams and fortified	l milk. Shortly after her meal				
	fed her. R8 allowed	CNA sat down to her left and I E18 to feed her and				
		I, bites of green beans, less at, less than 25% of her				
	potatoes, none of th	e power pudding, about 25%				
		and 100% of her ice cream. s recorded as 26-50% of her				
	entire meal.		A CONTRACT OF THE PARTY OF THE			
		s reviewed from 8/2/15 thru	THE CONTRACTOR OF THE CONTRACT		semple of the se	
		ose 80 meals documented,				
		led as "none" for intake. Of e recorded as R8 have 1-25%	Common of the co			Ì
	intake. There is no	documentation in the RD 's	v i marria madel		4 4	
		ogress notes during this time the facility identified R8	a a a depui de a delegación de la delegación delegación de la delegación delegaci			
		some meals and no evidence				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	ER: A. BUILDING:		COMPLETED						
					- (С					
		IL6013312	B. WING		09/15/2015						
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE							
IEDGEV	VILLE MANOR	1251 NOR	TH STATE	STREET							
JERSEYVILLE MANOR JERSEYVILLE, IL 62052											
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE					
S9999	Continued From page 12		S9999								
	they developed a plan to meet R8's nutritional needs when no intake is recorded in an effort to increase her caloric needs. On 9/10/15 at 9:10 AM, E1 Administrator stated										
	until August but agr gradually decreasin that facility should in not eat and offer so ensure food intake	ad a significant weight loss reed that her weight had been ag. E1 stated she understood dentify when a resident does mething later in an effort to occurs. E1 stated the weight attified her at risk and provided									
	documented R8 to loss in the past mor therapy, who recom and is receiving HC indicates the physic the weight loss with that R8 had experie infection requiring a evidence that the coconsidered any new increase R8's intake included her speech for safe eating.	mmittee note dated 8/13/15 have had a 12 pound weight hith, followed by speech mended a liquefied puree diet HP supplements. The note isian and family were notified of no new orders received and enced an upper respiratory intibiotics. There is no mmittee developed and/or interventions in an effort to e and nutritional status or in therapy recommendations									
WT ; the is measured to the control of the control	R8 has oral phase of been downgraded to continues that R8 reall intakes to ensure strategies. The note	tes, dated 8/12/15, document dysphagia and her diet had o liquefied puree. The note equires assistance of staff at use of safe swallow e documents R8's prognosis cellent support staff and the die directions.									
		PM, a policy and procedure requested. A policy entitled									

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED					
			A. BOILDING		l c					
		IL6013312	B. WING		09/15/2015					
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE						
JERSEYVILLE MANOR 1251 NORTH STATE STREET										
	CULAMADY CTA		ILLE, IL 62		ION					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE						
S9999	Continued From page 13		S9999							
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999							
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Illinois Department of Public Health